MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

## Pharmacy

**July 2007 • Bulletin 659**

**Contents**



### Providers Must Use New Claim Forms

Medi-Cal implemented the use of the *CMS-1500* claim form on June 25, 2007. Providers who previously submitted claims on the *HCFA 1500* must bill on the new *CMS-1500* claim form immediately. Providers not using the new *CMS-1500* should be in the process of transitioning. Failure to use the new form for claims submitted after June 25, 2007 may result in rejection of the provider's claim.

Also, Medi-Cal will not accept *CMS-1500* forms with bar codes. Some providers' systems are automatically printing bar codes on the form, which interferes with the claim adjudication process. Providers who have *CMS-1500* claim forms with bar codes should contact their software vendor to have this function removed.

Submission instructions for *Claims Inquiry Forms* (CIFs) and *Appeal Forms* require a copy of the corrected original claim form be attached. Old *HCFA 1500* claim forms will only be accepted for this reason.

### NPI Requirements for Medicare DME Suppliers

In accordance with the NPI Final Rule, Durable Medical Equipment (DME), prosthetics, orthotics and supplies (DMEPOS) suppliers are required to obtain a National Provider Identifier (NPI) for every business location. The only exception to this requirement is when a DMEPOS supplier is a sole proprietor (or considered an individual). A sole proprietor (Entity Type 1) is eligible for only one NPI regardless of the number of business locations.

The requirement for DMEPOS suppliers to obtain an NPI for every practice location also applies to DMEPOS suppliers who are enrolled with Medi-Cal. Providers with a Medi-Cal number prefix beginning with "DME," "XA," "GXA," "GFA," "XB," "GXB," "GFB," "XC," "GXC" or "GFC" must register a separate NPI subpart for each Medi-Cal number that begins with any of these prefixes. The only exception is for those providers who are a sole proprietor (Entity Type 1), as defined by the HIPAA – NPI Final Rule.

Failure to comply with this requirement may result in delayed processing or rejection of both Medicare crossover and direct bill Medi-Cal claims.

More information about NPI can be found in the NPI area of the CMS Web site at **www.cms.hhs.gov/NationalProvIdentStand**. Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) Web site at **https://nppes.cms.hhs.gov**, or call the NPI Enumerator at 1-800-465-3203 to request a paper application.

For more information about Medicare subpart expectations, please review the Medicare Subpart Guidance Paper at:
**www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf**.

### 2007 CPT-4/HCPCS Codes Reminder

Effective August 1, 2007, Medi-Cal will adopt the 2007 CPT-4 and HCPCS Level II codes. Claims billed for dates of service on or after August 1, 2007 must use the appropriate 2007 codes.

Codes to be added, modified or deleted were listed in the May 2007 *Medi-Cal Update*. Policy for new benefits was announced in the June 2007 *Medi-Cal Update*. Provider manual updates are included in this month's *Medi-Cal Update*.

### Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) were redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFO).

*This information is reflected on manual replacement pages dura bil dme 2 and 15 (Part 2), dura bil inf 1 (Part 2), mc sup 2 (Part 2), mc sup intro 1 (Part 2), tar field 1 thru 11 (Part 2) and tar sub drug 1 (Part 2).*

### Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that will impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

**Processing Change Schedule**
Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

| | |
|---|---|
| **May 2007** | **August 2007** |
| Sacramento Medi-Cal Field Office | Fresno Medi-Cal Field Office |
| **June 2007** | San Bernardino Medi-Cal Field Office |
| Northern Pharmacy Section (Stockton) | San Diego Medi-Cal Field Office |
| Southern Pharmacy Section (L.A.) | San Francisco Medi-Cal Field Office |
| **July 2007** | **September 2007** |
| L.A. Medi-Cal Field Office | TAR Administrative Remedy Section |
| In-Home Operations South | In-Home Operations North |

**Incomplete TARs**
CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

*Please see* **Processing Changes**, *page 3*

**Processing Changes** *(continued)*

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

**Adjudication Response**

CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

*Please see* **Processing Changes**, *page 4*

**Processing Changes** *(continued)*

**Attachments**
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

**SSN on TARs**
In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

**National Provider Identifier (NPI) Number**
Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

State of California - Health and Human Services Agency
Department of Health Services

CONFIDENTIAL

Medi-Cal Operations Division

ARNOLD SCHWARZENEGGER, Governor

# ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

| Svc # | Service Code | Modifier(s) | Service Description | From Date of Service | Thru Date of Service | Units | Quantity | Status | P.I. |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 123ABC | 1 | Service Description 1 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 1 Approve | 1 |
| 2 | ABC123 | 2 | Service Description 2 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 2 Modify | 0 |
| | **Reason(s):** | GEN: Modified, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 2 | | | | | | | |
| 3 | ABC123 | 3 | Service Description 3 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 3 Deny | 3 |
| | **Reason(s):** | GEN: Denied, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 3 | | | | | | | |
| 4 | ABC123 | 4 | Service Description 4 | 01-01-2006 | 01-31-2006 | 12345 | 1000000.123 | 4 Defer | 5 |
| | **Reason(s):** | GEN: Deferred, refer to comments | | | | | | | |
| | **Comment(s):** | Comments from Field Office Consultant 4 | | | | | | | |

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

### Billing Restrictions for Specific Power Operated Vehicle and Wheelchair Base Codes

Effective for dates of service on or after September 1, 2007, claims for power operated vehicle HCPCS code E1230 and power wheelchair HCPCS codes E1239, K0010, K0012 and K0014 are restricted to repair only and must be billed with modifier RP (repair). Claims must include documentation that the repair is for patient-owned equipment. Claims billed with modifiers NU (purchase) or RR (rental) will be denied. Providers billing for a purchase or rental of power operated vehicles or power wheelchairs must use the most current HCPCS codes.

HCPCS code K0011 (standard-weight frame motorized/power wheelchair with programmable control parameters) will continue to be available for the purchase, rental or repair of an iBOT Mobility System (billed with modifiers NU, RR or RP, respectively) or the repair of a K0011 power wheelchair. Only modifier RP is allowed for wheelchair code K0011 unless it is billed for an iBOT. Claims for any repair must document that the patient owns the chair.

*This information is reflected on manual replacement pages dura bil wheel 4, 6 and 10 (Part 2).*

### Rate Adjustments for Durable Medical Equipment Codes

Effective for dates of service on or after August 1, 2007, the following HCPCS codes for Durable Medical Equipment (DME) have been adjusted in accordance with statute:

- Code A4620 (variable concentration mask) will have a purchase-only rate of $0.58.
- Code E1002 (wheelchair accessory, power seating system, tilt only) will have revised reimbursement rates of $4,053.21 (purchase) and $405.32 (rental).
- Code E1353 (regulator) will have a purchase reimbursement rate of $26.30; rental reimbursement remains "By Report."
- Code E1355 (stand/rack) will have a purchase reimbursement rate of $19.80; rental reimbursement remains "By Report."

*This information is reflected on manual replacement pages dura cd 6, 9 and 18 (Part 2).*

### Oxygen Equipment and Contents Policy Updates

Effective for dates of service on or after August 1, 2007, selected oxygen policies are updated.

**Oxygen Contents Policies**
The following changes will be made to HCPCS codes E0441 through E0444 (oxygen contents):

For codes E0441 and E0442 (oxygen contents), providers must document on *Treatment Authorization Requests* (TARs) that the patient owns the stationary system for which the contents are requested.

For codes E0443 and E0444 (portable oxygen contents) only:

- For Medi-Cal purposes, codes E0443 and E0444 may be used to bill for portable oxygen contents, whether a portable system is rented or purchased.
- Modifier SC (medically necessary service/supply) is allowed for Durable Medical Equipment providers for use only with codes E0443 and E0444.
- A maximum of two units of portable oxygen contents is allowed per month. The first unit must be billed with modifier NU (purchase). If the second unit is billed for the same month of service, modifier SC must be used. The maximum reimbursement for the first unit is $61.96, and $16.87 for the second unit.

*Please see* **Oxygen**, *page 6*

**Oxygen** *(continued)*

- For Medi-Cal purposes, codes E0443 and E0444, "one month's supply equals one unit" is defined as follows:
  - For gaseous contents code E0443: 250 cubic feet for the first supply of contents and any amount for the second supply of contents (second unit).
  - For liquid contents code E0444: 110 pounds for the first supply of contents and any amount for the second supply of contents (second unit).

**Stationary Oxygen System/Concentrator Reimbursement**
Reimbursement rates for HCPCS codes E0424 and E0439 (stationary oxygen systems) and E1390 and E1391 (concentrators) are modified when billing with oxygen flow rate modifiers QE, QF and QG. The following chart shows the rates based on the code and modifier used.

| Code | Modifier RR | Modifier QE | Modifier QF | Modifier QG |
|---|---|---|---|---|
| E0424, E0439, E1390, E1391 | $158.72 | $79.36 | $238.08 | $238.08 |

**Billing Guidelines Chart**
The billing guidelines chart below has been updated to clarify policies.

| System Type | Modifier | Not Reimbursable in Same Month as Initial Purchase |
|---|---|---|
| Stationary Gas (Purchase) E0425 | NU | A4615, A4619, A4620, E0424, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353, E1390, E1391 |
| Stationary Liquid (Purchase) E0440 | NU | A4615, A4619, A4620, E0424, E0425, E0430, E0431, E0439, E0441, E0443, E0555, E1353, E1390, E1391 |
| Portable Gas (Purchase) E0430 | NU | A4615, A4619, A4620, E0431, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353, E1392 |
| Portable Liquid (Purchase) E0435 | NU | A4615, A4619, A4620, E0424, E0425, E0430, E0431, E0434, E0441, E0443, E0555, E1392 |
| Concentrator (Purchase) E1390, E1391 | NU | A4615, A4619, A4620, E0424, E0425, E0439, E0440, E0441, E0442, E1353 |
| Stationary Gas (Rental) E0424 | QE, QF, QG, RR | A4615, A4619, A4620, A9900, E0425, E0434, E0435, E0439, E0440, E0441, E0442, E0444, E0555, E1353, E1390, E1391 |

*Please see* **Oxygen**, *page 7*

**Oxygen** *(continued)*

| System Type | Modifier | Not Reimbursable in Same Month as Initial Purchase |
|---|---|---|
| Stationary Liquid (Rental) E0439 | QE, QF, QG, RR | A4615, A4619, A4620, A9900, E0424, E0425, E0430, E0431, E0440, E0441, E0442, E0443, E0555, E1353, E1355, E1390, E1391 |
| Portable Gas (Rental) E0431 | RR | A4615, A4619, A4620, A9900, E0430, E0434, E0435, E0439, E0440, E0442, E0444, E0555, E1353 |
| Portable Liquid (Rental) E0434 | RR | A4615, A4619, A4620, A9900, E0424, E0425, E0430, E0431, E0435, E0441, E0443, E0555 |
| Concentrator (Rental) E1390 E1391 | QE, QF, QG, RR | A4615, A4619, A4620, A9900, E0424, E0425, E0439, E0440, E0441, E0442, E1353 |
| Concentrator (Rental) E1392 (Portable) | RR | A4615, A4619, A4620, A9900, E0430, E0431, E0434, E0435, E0441, E0442, E0443, E0444 |

*The updated information is reflected on manual replacement pages dura bil oxy 2, 6 and 8 thru 11 (Part 2) and dura cd 8 (Part 2).*

### TAR Requirement, Code Conversion for Botulinum Toxin Type A and B Injections

Effective for dates of service on or after August 1, 2007, botulinum toxin A (Botox®) will convert from local HCPCS code X7040 (10 units) to national HCPCS code J0585 (per 1 unit). Botulinum toxin B (Myobloc®) will convert from local HCPCS code X7042 (2,500 units) to national HCPCS code J0587 (100 units).

Botulinum toxin A and B are neuromuscular blocking agents used to treat various muscle disorders, and require a *Treatment Authorization Request* (TAR) for reimbursement. The TAR must have documentation justifying medical necessity including specific details regarding treatment, dosage and diagnosis.

Botulinum toxin A (Botox®) dosages are recommended up to 600 units in adults and 400 units in children. Botulinum toxin B (Myobloc®) is used in doses up to 25,000 units. However, higher dosages may be approved based on submitted TAR documentation supporting the medical necessity of the dosage used.

If surgical CPT-4 codes are billed, providers should use modifier AG for the primary surgeon, and modifier ZM or ZN for the use of supplies or other drugs. When recipients require electromyography (EMG), endoscopy or anesthesia or sedation when receiving botulinum toxin A or B, those procedures may be reimbursed if billed on the same date of service as the drugs and accompanied by an approved TAR for J0585 and J0587. If two or more sites are injected on the same date of service, providers will bill for the total amount of botulinum toxin units injected.

*Please see* **Botulinum**, *page 8*

**Botulinum** *(continued)*

Examples of conditions and diagnoses that result in muscle spasm that may benefit from treatment with botulinum toxin A or B are as follows:

- Cerebral palsy
- Multiple sclerosis
- Spinal cord injuries
- Cerebrovascular accident
- Spastic hemiplegia
- Blepharospasm
- Strabismus
- Torticollis
- Hemifacial spasm
- Spasmodic dysphonia
- Achalasia and cardiospasm *
  - * Achalasia and cardiospasm treatment with botulinum toxin A or B should be used only if the patient has failed conventional therapy, is at high risk of complications from pneumatic dilatation or surgical myotomy, or if previous procedures have failed or caused a perforation.
- Hyperhidrosis
- Frey's syndrome
- Detrusor hyperreflexia
- Detrusor sphincter dyssynergia
- Anal sphincter spasm
- Anal fissure

Non-medically necessary uses of botulinum toxin such as treatment of headaches, pain syndromes or cosmetic purposes (for example, facial wrinkles) are not reimbursable. In addition, claims for treatments that will not improve function, seem to be investigational, or are considered unsafe and ineffective will be denied.

Botulinum toxin A and B requests for children under 21 years of age require prior authorization by the California Children's Services (CCS) program.

*This information is reflected on manual replacement pages inject 22 and 23 (Part 2).*

### Vaccine Billing Clarification

Providers are reminded to bill CPT-4 code 90471 (immunization administration; one vaccine) to Medi-Cal to be reimbursed for the administration of vaccines that are free to the provider through a source other than the Vaccines For Children (VFC) program.

When billing code 90471, providers must indicate the vaccine administered and its source in the *Reserved for Local Use* field (Box 19) of the claim. Code 90471 may not be billed in conjunction with other vaccine injection codes (90281 – 90749 and X5300 – X7699) administered by the same provider, for the same recipient and date of service.

*This information is reflected on manual replacement pages inject 1 and 2 (Part 2).*

### New Public Health Department Oversees Children's Treatment Program

Effective July 1, 2007, the Children's Treatment Program (CTP) is no longer organized under the California Department of Health Services (CDHS) and has the following new address:

California Department of Public Health
1616 Capitol Avenue, Suite 74-317
MS 5203
P.O. Box 997377
Sacramento, CA 95899-7377

The address change is part of a CDHS reorganization. CDHS is split into the following separate departments:

- California Department of Public Health (CDPH)
- California Department of Health Care Services (CDHCS)

CTP is under control of the public health (CDPH) department. Claim submission and processing procedures for CTP remain the same.

Information about the CDHS reorganization is available on the Web at **www.dhs.ca.gov/home/organization/reorganization**.

*This information is reflected on manual replacement pages prog 5 (Part 1) and children 1 thru 3 (Part 2).*

### Family PACT Program To Release New Provider Manual

The Family PACT (Planning, Access, Care and Treatment) Program will release its new provider manual in October 2007. This new manual will replace the current *Policies, Procedures and Billing Instructions* (PPBI) manual. Providers are asked to use the new manual once it is received.

**New Manual Features**
The new Family PACT Program provider manual will contain several new features that will help ensure its overall quality and usefulness. These features will include:

- A user-friendly format and style similar to that currently found in the Medi-Cal provider manuals
- Unique section titles with locator keys to quickly identify sections of interest
- An online version for providers to access and view

**Subscription Process – Enrolled and Non-Enrolled Providers**
All enrolled Family PACT Program providers will automatically receive an initial copy of the new Family PACT Program provider manual at no charge. Non-enrolled providers (subscribers) must complete a *Subscriber Order Form* and will be charged for a copy of the new provider manual. The *Subscriber Order Form* will be available in a future *Medi-Cal Update*.

Additional provider manual orders will be available for a nominal subscription charge for Family PACT providers and subscribers who would like more than one provider manual.

Annual subscriptions include monthly bulletin updates, manual replacement pages and other program-related special mailings. Monthly updates ensure that providers have access to the most current program policies and procedures.

Family PACT providers will continue to receive monthly bulletin updates, manual replacement pages and other program-related special mailings as long as they remain active providers. Family PACT providers who subscribe to receive additional manuals will have their subscriptions renewed, at no charge, upon the provider's submission of an annual renewal notice. Non-enrolled providers who subscribe, such as pharmacies and laboratories, will be charged for annual subscription renewals.

*Please see* **Family PACT**, *page 10*

**Family PACT** *(continued)*

**Contact Information**
For more information regarding the Family PACT Program, please call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

## Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. Dates for upcoming sessions are listed below. Registration begins at 8:00 a.m., with Session I beginning promptly at 8:30 a.m.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and client eligibility enrollment supervisors, are encouraged to attend, but are not eligible to receive a *Certificate of Attendance*. Enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. The new session format offers the option for currently enrolled providers and staff to attend only the afternoon update session along with the clinical session or the billing and coding session.

**Session I – *Overview of the Family PACT Program*:** 8:30 a.m. to 12:30 p.m. Attendance at this presentation is mandatory for clinician providers wishing to enroll in Family PACT and is recommended for other staff who are new to the program or need a refresher.

The afternoon sessions run concurrently from 1:30 p.m. to 4:00 p.m. and start with an update from the Office of Family Planning – ***What's New in Family PACT*** from 1:30 p.m. to 2:00 p.m.

**Session II – *Clinical Practice Alerts*:** 2:00 p.m. to 4:00 p.m. Clinicians in attendance who wish to become a Family PACT provider must also attend this session. Free continuing education (CE) credit is available for Session II. Please bring your medical license number with you if requesting CE credit; a continuing education request form will be available during onsite registration. Other interested clinical staff are welcome to attend and may request free CE credit for this session.

**Session III – *Billing and Coding Basics* Roundtable:** 2:00 p.m. to 4:00 p.m. Administrators and billers interested in Family PACT billing information may attend.

Please note the upcoming Provider Orientation and Update Sessions below.

| ***Pasadena*** | ***Chico*** | ***San Diego*** |
|---|---|---|
| **August 14, 2007** | **October 11, 2007** | **November 1, 2007** |
| **8:30 a.m. – 4:00 p.m.** | **8:30 a.m. – 4:00 p.m.** | **8:30 a.m. – 4:00 p.m.** |
| Hilton Pasadena | Oxford Suites | Holiday Inn on the Bay |
| 168 S. Los Robles Avenue | 2035 Business Lane | 1355 N. Harbor Drive |
| Pasadena, CA 91101 | Chico, CA 95928 | San Diego, CA 92101 |
| (626) 577-1000 | (530) 899-9090 | (619) 232-3861 |

For a map and directions to these locations, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the appropriate location.

**Registration**
To register for an orientation and update session, go to the Family PACT Web site (**www.familypact.org**) and click "Providers" at the top of the home page, then "Provider Training," and finally, click the "Registration" link next to the appropriate date and location and print a copy of the registration form. Please identify the session(s) you plan to attend.

*Please see* **Provider Orientation**, *page 11*

**Provider Orientation** *(continued)*

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

**Check-In**
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:00 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

**Note:** Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

**Certificate of Attendance**
Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

**Contact Information**
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*

## CCS Service Code Groupings (SCGs) Update

Effective for dates of service on or after August 1, 2007, a number of codes are end-dated and added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 04, 05, 06, 07, 10 and 12.

**Reminder:** SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

*The updated information is reflected on manual replacement pages cal child ser 1, 3 thru 16, 18 thru 20 and 22 thru 25 (Part 2).*

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| | |
|---|---|
| Remove and replace: | *Contents for Pharmacy Billing and Policy* iii thru vi *<br>blood 1/2 * |
| Remove:<br>Insert: | cal child ser 1 thru 27<br>cal child ser 1 thru 26 |
| Remove and replace: | children 1 thru 4<br>cif co 7 thru 11 *<br>cif sp 1 thru 10 *<br>cms comp 1/2 *<br>dura 9/10 *<br>dura bil dme 1/2, 15/16<br>dura bil inf 1/2<br>dura bil oxy 1/2, 5 thru 12<br>dura bil thp 1/2 *, 5 thru 10 * |
| Remove:<br>Insert: | dura bil wheel 3 thru 10<br>dura bil wheel 3 thru 12 |
| Remove:<br>Insert: | dura cd 1 thru 24<br>dura cd 1 thru 30 |
| Remove and replace: | dura cd fre 1 thru 4 *<br>inject 1/2, 5/6 *, 21 thru 24, 41 thru 44 * |
| Remove:<br>Insert: | inject 59 thru 60<br>inject 59 thru 61 * |
| Remove and replace: | mc sup 1/2<br>mc sup intro 1/2<br>mc sup lst3 1 thru 12 * |
| Remove and replace: | mc sup man cd 3/4 *, 9/10 * |
| Insert new sections after the *Medical Supplies: Medicare Covered Services* section: | mc sup prod ost ind 1 * (new)<br>mc sup prod ost1 1 thru 19 * (new)<br>mc sup prod ost2 1 thru 5 * (new)<br>mc sup prod ost3 1 thru 11 * (new)<br>mc sup prod ost4 1 thru 11 * (new) |
| Remove and replace: | medi non hcp 1/2 *<br>ortho 1/2 *, 9 thru 15 *<br>ortho cd1 1 thru 10 *, 25 thru 28 *<br>ortho cd2 9/10 * |
| Remove:<br>Insert: | ortho cd2 13 thru 22<br>ortho cd2 13 thru 21 * |
| Remove and replace: | sub acut adu 3/4 *<br>tar field 1 thru 11<br>tar sub drug 1/2<br>tax 5 thru 8 * |